This form may be filled in and printed on line

RI Governor's Commission on Disabilities

RI GCD Form I 1. REQUEST FOR REASONABLE ACCOMMODATIONS / MODIFICATIONS

Name		**Day Phone #**		**Circle if TTY**
Address			**If state employee list Social Security number**	

☑ Accommodation for:	**☐ applicant for state employment**	**☐ consumer of state services**
	☐ state employee	**☐ consumer of state funded services**
	☐ student at state operated school	**☐ applicant for state services**
	☐ student at state college	**☐ resident at a state operated institution**

Name and location of the: **program, service, activity OR Job needing accommodation(s)**	

Due to my disability I may require: reasonable accommodation(s) to perform the essential function(s) of the job listed above OR reasonable modification(s) of policies and procedures, OR auxiliary aids to participate in the program, service or activity listed above. I hereby request that the agency's ADA Coordinator contact me regarding this request and authorize the agency to verify the information provided in this request.
I understand that I may be required to provide proof that:

- **I have physical and/or mental impairments that substantially limit my ability to perform one or more major life activities** (such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.)

I have listed below my impairments:	**☑ The major life activities which are limited:**	
	☐ caring for oneself ☐ performing manual tasks ☐ walking ☐ seeing ☐ hearing	☐ speaking ☐ breathing ☐ learning ☐ working ☐ reproduction

and that these limitations prevent me from:
1) performing the essential functions of the job OR
2) participating in or enjoying the benefits of state services.
I have listed below the essential functions or parts of the program, service or activity I am unable to do without a reasonable accommodation, modification or auxiliary aids and services:

(attach additional sheets if necessary)

RI Governor's Commission on Disabilities

☑ Nature of the request (check one or more)	**☐ change in how a job is performed**	**☐ modification of policies and procedures**
	☐ purchase of auxiliary aids (assistive technology) *[complete page 3]*	**☐ provision of auxiliary services (interpreter for the deaf, reader, etc.)**
	☐ removal of accessibility barriers (build ramp, modify bathroom, etc.)	**☐ other (describe below)**
Describe the accommodations requested:	**(attach additional sheets if necessary)**	

I do hereby authorize the State of Rhode Island to acquire the (medical/personnel or other) information needed to verify my claim of disability and limitations on my ability to perform some essential functions of the job or participate in or otherwise enjoy the benefits of state services. I further understand that the ADA regulations require information regarding my medical condition or history shall be collected and maintained on separate forms and in separate medical files and be treated as a confidential medical record expect:

1. The state agency's ADA Coordinator may review all information provided to verify my claim of a disability, need for a reasonable accommodation and to develop a reasonable accommodation plan;

2. The state's rehabilitation / disability services experts may review all information provided to verify my claim of a disability and need for a reasonable accommodation / modification / auxiliary aids, to conduct a job or task analysis and develop a reasonable accommodation plan;

3. Supervisors and managers may be informed regarding necessary restrictions on my work, duties or participation in services (but not the nature of my disability);

4. First aid and safety personnel may be informed when appropriate if my disability might require emergency treatment; and

5. Government officials investigating compliance with the ADA or other disability rights laws.

I authorize	**(Health Care Professional's Name)**	
Address:		
Phone #:		

to release my medical records to verify that I have physical and / or mental impairment(s) that substantially limit one or more major life activity and that these limitations prevent me from performing the essential functions (listed above) of the job or from participating in or otherwise enjoying the benefits of state services (listed above).

Signature:		**Date:**	

Mail or present this form to the state agency's ADA Coordinator.

For state agency use:	***Received by:***		***Date form was received***	

Complete page 3 only if requesting auxiliary aids (assistive technology/equipment)
Description of Requested Auxiliary Aids (EQUIPMENT SPECIFICATIONS)
(attach additional sheets if necessary)
Addresses for Potential Vendors
(attach additional sheets if necessary)
If requesting auxiliary aids – During the development of the reasonable accommodation plan the Agency ADA Coordinator shall send a copy of the complete request and a attach job / task analysis and medical assessment regarding the need for the equipment requested to: **Governor's Commission on Disabilities Howard Complex 41 Cherry Dale Court Cranston, RI 02920-3049**

Agency ADA Coordinator's Name	
Telephone and e-mail	

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To be completed by the ADA Equipment Committee	**Request received on**	
Date(s) of hearing on request		**Present at the hearing:**
☑ outcome of Committee hearing	**☐ approved** **☐ not approved** **☐ modified**	Agency ADA Coordinator _____ Requesting Party _____ Others:
If not approved or if modifying, Committee's reasons:		

Equipment Approved By ADA Equipment Committee Specifications And Estimated Cost

Order Code	Description	Vendor # 1 Price	Vendor # 2 Price	Vendor # 3 Price

Items purchased	Date Ordered	Date Delivered

Signature of Agency Official Accepting equipment:	**Date**